

Section Two

Targets for Improvement

Section Two: Targets for Improvement

Section I presented the missions of the department as they exist and relate to each other under the two historical responsibilities of public health practice in Texas:

1. Essential Public Health Functions

2. Health Care Safety Net Functions

[Related to Health and Safety Code Chapter 11, Sec 11.0045 (c)(1) and (c)(2), referred to as the “TDH Missions Charge”].

Then it provided an assessment of how current programs and services of the department align to accomplish those responsibilities, reviewed the capacity of the department to perform its job, and discussed challenges that must be addressed to optimally coordinate the department to best carry its responsibilities. [Related to Health and Safety Code Chapter 11, Sec 11.0045 (c)(6), referred to as the “Internal Assessment Charge”].

This section outlines specific targets for improvement that the department will aim toward to bring about the additional coordination and alignment that is needed. These targets resulted from the workgroup activities that were undertaken to address the charges outlined in HB 2085 and were derived from the findings and recommendations of those workgroups. It is now up to the department to commit to accomplishing these targets.

The Targets for Improvement are:

- *TARGET ONE: Manage and administer department resources toward more effective public health practice*

[Primarily related to the “Program Integration Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c)(3) and (c)(4); “Internal Assessment Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c)(6); the “Coordination with Other Agencies Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c)(9); and the “Mandated Plans Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c)(10) and (c)(11)],

- *TARGET TWO: Enhance the collection and use of health information for public health impact*
[Primarily related to the “Data Management Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c)(5); and the “Health Information Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c) (8)],
- *TARGET THREE: Increase alignment of TDH employees to the department’s missions*
[Primarily related to the “TDH Missions Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c)(1) and (c)(2)],
- *TARGET FOUR: Build and enhance essential public health functions at the local level*
[Primarily related to the “Internal Assessment Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c)(6); and the “Coordination with Other Agencies Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c)(9)],
- *TARGET FIVE Strengthen regulatory activities*
[Primarily related to the “Regulatory Review Charge,” HB 2085 Sec 1.23],
- *TARGET SIX: Integrate the function of health care delivery programs*
[Primarily related to the “Service Integration Charge,” Health and Safety Code Chapter 12 Subchapter B, Sec. 12.0115; the “Program Integration Charge,” Chapter 11, Sec 11.0045 (c)(3) and (c)(4); and the “Coordination with Other Agencies Charge,” Chapter 11, Sec 11.0045 (c)(9)],
- *TARGET SEVEN: Involve stakeholders in agency planning and decision-making*
[Primarily related to the “Stakeholders Charge,” Health and Safety Code Chapter 11, Sec 11.0045 (c)(7) and Health and Safety Code Chapter 12, Subchapter A, Sec 12.004; and the “Coordination with Other Agencies Charge,” Chapter 11, Sec 11.0045 (c)(9)].

“Index of Responses to HB 2085 Blueprint Charges” at the end of Section II presents a more complete guide to the department’s responses to the specific charges of HB 2085.

TARGET ONE: Manage and administer department resources toward more effective public health practice

Problem

The Texas Department of Health holds ultimate statutory responsibility for ensuring that the functions of public health exist for the people of Texas. The department strives to diligently carry out its mandated programmatic duties and responsibilities, but it is challenged to develop a cohesive approach to health improvement. By ensuring that its management and resources are aligned in effective public health practice, the department can be more confident that it is working successfully among the many components of Texas' public health system and that coordinated programmatic efforts demonstrate impact on the public health priorities in the state.

Background

As a state agency charged with preventing disease and promoting health in the state, TDH potentially touches all of the state's twenty million citizens, its visitors, and people worldwide who consume its products. The history of the department (Chapter One) illustrates how the scope of the agency came to be so broad—as broad as the definitions of health, the perceived health threats, and the opportunities for health improvement. The history also demonstrates that as the department grew in reaction to priority issues, it did so (as the Sunset Advisory Commission Staff Report points out) without defining a cohesive framework that reflects priorities or general overarching direction for public health activities throughout Texas—neither for itself, nor in relation to the many components of the state public health system.

As a result, the department today most resembles a collection of targeted programs and divisions, and the primary attention of the department is directed more toward *administering programs* than *performing public health functions* (described in Chapter One as the department's health care safety net functions and the essential public health functions of the Texas Health and Safety Code, Chapter 121). TDH administrative functions have evolved to support categorically funded and managed programs that too frequently operate in isolation.

Appendix C and Appendix G point out several key challenges to be addressed:

- Some programs are constrained in their ability to assess the needs and demands related to their areas of expertise. Sometimes, programs lack specific health information. Sometimes, programs cannot find the resources or technical expertise they need to help them assess and define their priority issues.
- Strategic planning in the department does not coordinate program, management, and agency-wide objectives as fully as possible. Improved coordination in planning would help align programs to achieve state public health priorities.
- When priorities are not clear within or between programs, it becomes difficult to appropriately allocate resources and efficiently implement programs.
- Program management strategies are not linked in department-wide evaluation, and it is difficult to determine impact or cost effectiveness of the department's efforts.

Without strong linkages to each other and without knowing how they align to achieve state health priorities, programs may be missing opportunities to maximize resources for effective results.

The potential for missed opportunities increases when the department's activities are viewed in the context of the state's larger public health system. Though the department's enabling statutes describe a strong role for the department (see Chapter One), essential public health functions and health care safety net functions are carried out in Texas through a varied assortment of partners—federal, state and local; public and private sector—that together form a loosely allied system of public health for the state. At times, the role of the department in this system is unclear for two key reasons:

1. The inherently governmental functions of public health have not been clearly delineated. The practice of public health — ensuring that the conditions necessary for people to be healthy are present and maintained — includes a role that **only** government can play. The department was founded on one such duty: quarantine by a governmental health authority to control disease outbreaks.

Of all the public health duties, which are inherently (and exclusively) governmental? Which duties are better handled by private business or not-for-profit agencies? And, what is the role of the government in addressing the public health needs that are not inherently governmental, but not best met by private and not-for-profit agency efforts? These questions have not been fully answered yet in Texas.

2. *Jurisdictional responsibilities between the state and local levels are not always clear.* The Local Public Health Reorganization Act (Chapter 121 of the Texas Health and Safety Code) outlines the statutory provisions for public health functions by local governments. The statute permits but does not require local governments to perform public health functions, and the state is expected to perform the functions if local governments opt out. The workgroup of state and local partners formed to study state and local public health under House Concurrent Resolution 44 of the 75th Legislative Session noted that “while Texas law gives the ultimate responsibility for public health to the state, some essential public health services are better overseen at the state level and some are more appropriate for local governments.” The group concluded: “We realize this delineation is not always clear, and while we do not believe it should be defined in legislation, we believe this issue deserves further study.”

In fact, the roles and responsibilities of state and local agencies have been clearly delineated in state statute for many specific public health functions. However, how fully the public health functions are performed at the local level depends on which components of state and local agencies are present in any given place, and how those components work together to address public health problems as they occur. In an area that lacks local services, the responsibility for action falls on the TDH Regional Director who serves as the local health authority, constrained by availability of resources and competing needs.

The components of the state’s system vary widely in capacity, in needs, and in actual existence at the local level. In order to ensure that the needs of Texans are being adequately met, a successful public health system must bridge the historical disconnects in the roles and relationships among programs in the department, between state and local stakeholders, and among state agencies that carry out the state government’s role.

TARGET ONE: Manage and administer department resources toward more effective public health practice.

TDH will manage and administer its resources to perform its mandated duties and public health practice responsibilities in alignment and coordination with the state public health system.

TDH will:

1. As the response to the HB2085 requirement for subsequent Comprehensive Strategic and Operational Plans, write a Public Health Improvement Plan that defines the priority public health issues for the state. The plan will describe agency and public health system goals, objectives, strategies, outcomes, and benchmarks for comparisons with other states and will serve as a vehicle for the alignment and coordination of department services and programs.

- a) Include in the plan a delineation of statewide priorities drawn from local and regional public health improvement plans.*
- b) Include in the plan a state health status report, using community and state health status indicators.
- c) Include in the plan an assessment of public health performance based on the state and Local Public Health System Performance Standards published by the federal government and adopted by the department.
- d) Include in the plan an update on the Service Delivery Integration project.
- e) Include in the plan an evaluation of the progress made in increasing involvement of agency stakeholders in agency planning and decision-making.
- f) Include in the plan specific proposed actions to meet deficits in essential public health functions statewide.

* See Target 4, item 3.

- [illegible]

- c) Identify professional competencies in essential public health functions as relevant to TDH positions, and include those competencies as elements of job descriptions (for example, in descriptions of required knowledge, skill, and ability).

4. Include within departmental planning and legislative initiatives an explanation of how the plan or initiative will help accomplish the priorities of the Public Health Improvement Plan.

- a) In the development of the department's proposed legislation and budget appropriation requests, include an assessment of how the proposed items support accomplishing the priorities of the Public Health Improvement Plan. Work with the legislature to enable the passage of legislation that facilitates better coordination of new programs into the existing organizational structure and processes.
- b) Through the agency's Biennial Strategic Plan, work with the Legislative Budget Board and the Legislature to develop outcome performance measures that reflect the Public Health Improvement Plan.

5. Perform an evaluation of department activities that documents program-specific and agency-wide impacts on health outcomes in Texas.

- a) Enhance current evaluation efforts by training TDH central office and regional staff and local health departments on how best to evaluate their implementation process, cost efficiencies, impact on health outcomes, and benchmarks.
- b) Evaluate the achievement of the outcomes in the Public Health Improvement Plan by TDH and its partners; include comparison of Texas' progress toward benchmarks to the progress of other states. Include a report of evaluations in subsequent Public Health Improvement Plans.
- c) Evaluate TDH programs' progress toward achieving the state's priority health issues as stated in the Public Health Improvement Plan.

TARGET TWO: Enhance the collection and use of health information for public health impact**Problem**

The capacity of the Texas Department of Health to adequately identify health problems and describe health needs is limited by the availability of timely localized data and the availability of epidemiologic skill to monitor, investigate, and diagnose. Texas is vulnerable when it cannot identify patterns of disease occurrence (like hepatitis outbreaks or cancer clusters). This vulnerability is especially acute in the threat of bioterrorist attack.

Moreover, effective public health practice is inhibited because local communities lack appropriate health information to help them define local priorities and mobilize for health improvement. This also hinders prioritization of health threats and rational resource mobilization at the state level.

Background

Good, timely, localized data is the currency of effective public health practice. Chapter One explained that the essential public health functions begin with assessment and investigation. Chapter Two pointed out that current deficiencies hinder assessment and prioritization of health problems locally. This in turn limits program effectiveness and prevents the larger assessment of health needs that would most legitimately inform allocation and deployment of the department's resources in the first place.

The traditional monitoring and assessment functions of public health are what yield needed information on the incidence and prevalence of diseases as well as information on behaviors that lead to the loss of health. They also provide information on other factors that predispose to disease—the indicators of the health of a community.

Control of illness and disease first requires understanding of which health problems affect which people in which places. This depends on good data collection and distribution systems. This is first critical within communities where this information is

most needed, most wanted, and will generate the most results. As Appendix A discusses reliable data must be available, data must become information, and information must be applied to guide priorities, decisions and actions to improve health.

Much useful data currently exists at the department. Appendix D discusses the varied data bases in the department and the types of information they contain. These include reportable diseases, registries, specific surveys like the Behavioral Risk Factor Survey, and vital statistics, as well as confidential client service data within programs. But constraints in the usability of these data exist.

Due to reporting and processing time lags, to the lack of locale-specific information in reporting requirements, and to the technical and technological incompatibilities between data sets, as Appendix D notes, it has proven difficult to produce timely health information for the department and local communities to use. As a result, it is hard to detect patterns of health problems and disease clusters, and more acutely, rapid outbreaks of disease occurring naturally or as the result of bioterrorist attack. This inhibits our ability to react and respond to control health problems.

Moreover, data and investigation constraints inhibit the department's efforts to understand what keeps people safe and healthy and to catalyze community and state action. The department provides local health data to communities to the extent it can, but improved public health practice requires better interpretation of data that exist, more focused information at the community level, and better ways of delivering such data to communities.

TARGET TWO: Enhance the collection and use of health information for public health impact

The department will enhance the collection and use of health information for public health impact.

TDH will:

1. Develop a statewide data collection and management system that supports the

department's leadership in assessing and improving the health of Texans, assists communities in assessing and addressing their own health needs, and measures the effectiveness of interventions.

- a) Improve the availability and accessibility of community-based information for use by TDH programs and customers. Specifically, develop integrated databases of standard health indicators and develop an internet-based query system to allow public access to data (while maintaining safeguards to protect the privacy of individuals).
- b) Expand geocoding activities so that all vital statistics and reportable disease incidence data are available for analysis through geographic information systems. Code the data at the most local level possible and make it available for public access via the internet (while maintaining safeguards to protect the privacy of individuals).
- c) On a continuing basis, assess the department's strengths in providing necessary data to stakeholders, consumers, and employees.
- d) Create a State Center for Health Statistics in the department that will coordinate the department's data and share data with other agencies to ensure that overall direction is consistent among state programs and that all state information resources are available for decision-making.

2. Improve the department's ability to detect and respond to community health problems, including epidemics and bioterrorist attacks.

- a) Establish epidemiology and surveillance teams (consisting of an epidemiologist, a public health technician, a nurse, and an information specialist) in each of the department's public health regions to link with the central office and work with communities in conducting local investigations, monitoring health indicators, identifying health problems, and selecting priority health needs.

- b)** Reprioritize TDH resources so the department is able to provide deeper epidemiological analysis of existing disease incidence and survey, registry, and vital statistics data.
- c)** Augment the epidemiologic and analysis skills of public health professionals at the central, regional, and local levels through a continuing education program. Include methods to assess the root causes of public health problems.
- d)** Train public health professionals and communities on tools for presenting health information and on processes for making public policy decisions based on health information.

***TARGET THREE: Increase alignment of TDH employees
to the department's missions***

Problem

Achievement of the department's missions relies on aligning the most valuable organizational asset - TDH employees - to effectively and efficiently carry out its work. Alignment increases the department's ability to focus its energy, to ensure that TDH staff is working toward the same outcomes, and to adjust the organization's direction in response to a changing environment. Once strategic plans have laid the foundation for priorities and resource allocation, training and staff development are necessary to ensure that the skills and competencies of the workforce are aligned for effective public health action.

Background

Public health is comprised of many professional disciplines such as epidemiology, statistics, environmental sciences, health promotion, health services administration, social work, nutritional sciences, the behavioral sciences, and health care professions like medicine, nursing, and dentistry. TDH has always attempted to hire highly qualified professionals to carry out public health functions within the state and has made efforts to provide job relevant training for public health professionals at both the state health department and local health departments, but efforts are intermittent and uncoordinated.

Appendix C points out that while high levels of skills and public health competencies exist in the department, employees in positions throughout the agency's personnel classifications can benefit from increased orientation to the basic foundations of public health practice. Training in how the department fulfills its health care safety net functions and the essential public health functions can contribute a needed linkage between program activities and public health outcomes in the state. Also, in a state with as much ethnic diversity as Texas, a key to effective public health practice will include training on cultural competency.

Public health training and development opportunities have flourished nationwide since the establishment of the Centers for Disease Control and Prevention's Public Health Training Network (PHTN). PHTN is appropriately named because it is a network in several senses:

1. It is a network of interdependent activities for developing and delivering high quality, distance-based training to state and local health workers at all levels;
2. It is a network of partners in disease prevention who work together to carry out the activities; and
3. It is a network of shared resources of people and access to technology.

Leveraging resources such as PHTN and other continuing education tools provided by public health organizations such as American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), Pan American Health Organization (PAHO), University of Illinois at Chicago School of Public Health Center for the Advancement of Distance Education (CADE), National Laboratory Training Network and others will enable the department to develop training curricula and staff development opportunities to maximize the potential of public health professionals throughout the state and achieve the department's missions.

TARGET THREE: Increase alignment of TDH employees to the department's missions

The department will enhance its employees' understanding of its missions in order to increase alignment, coordination, and effectiveness in performing the department's mandated duties and responsibilities.

TDH will:

1. Enhance the awareness and understanding of all department employees of the public health foundations on which our responsibilities and duties rest.
 - a) Develop training curricula on: the basic principles of public health (including the essential public health functions set out in Texas law) and the role of the department in implementing those principles in Texas; the department's health care safety net functions; and basic public health leadership and management and cultural competency.

- b) Using these curricula, establish a mandatory program that provides position-appropriate levels of training for all employees, to be initiated at new employee orientation and given periodically during an employee's career.

TARGET FOUR: Build and enhance essential public health functions at the local level

Problem

Texas cannot rest assured that the essential public health functions needed to ensure the conditions necessary for people to be healthy exist to serve all people of the state where they live, work, play. Basic disease control, sanitation, epidemiology, and community mobilization activities are not visible in many communities in Texas.

Communities need protection from hazards that can threaten the health of the entire population. Moreover, they need support in developing their own priorities and their own solutions for improving their health. Texas needs to enhance and strengthen its local public health systems statewide, supported and served by unified and aligned state public health resources.

Background

The term *local public health* refers to the level of public health practice that originates in and works within “local” political jurisdictions such as municipalities and counties, taking its cues from the Local Public Health Reorganization Act (Chapter 121 of the Texas Health and Safety Code). A foundational part of the state’s public health policy, the Local Public Health Reorganization Act outlines the statutory provisions for public health functions by local governments. The statute permits but does not require local governments to perform public health functions, and the state is expected to perform the functions if local governments opt out.

The Reorganization Act permits a TDH Regional Director to perform the duties of a health authority at the request of local governments and allows TDH to contract with governmental entities that provide public health services. House Bill 1444 of the 76th Legislative Session made an important contribution to the Reorganization Act in its codification of the ten essential public health functions. However, the Reorganization Act neither establishes the responsibilities of state and local governments in performing the essential public health functions, nor provides a mechanism for funding those functions.

The department's *Self-Evaluation Report* to the Sunset Advisory Commission in 1997 highlighted difficulties and dangers that this produces. In communities where there is no local health department, the department is called upon to respond when health urgencies and emergencies arise (possibly involving TDH Regional Directors as *de facto* local health authorities). This creates the impression that public health activities need only be reactive, and that it is the responsibility of the state to react. In communities where local health departments do exist, the essential public health functions compete for scarce funds with health care service duties. Many local departments borrow from fee-based or grant-related staff to react to public health urgencies and struggle to find resources to do the more proactive and preventive essential functions. As Appendix C points out, existing programs work to meet their mandates to serve particular diseases or populations, but rarely are they able to provide statewide coverage. Meanwhile, the foundational public health activities that should serve and protect all people statewide are patchy and coverage is scattershot. The people of Texas cannot be assured that the basic conditions for protecting and improving their health are in place regardless of where they live, work, and play.

The state and local workgroup formed to study public health under House Concurrent Resolution 44 of the 75th Legislative Session developed some basic tenets that characterize an effective local public health system. These tenets also summarize the workgroup's belief in the importance of carrying out the essential functions at the local level:

- All direct public health actions should happen at the local level if they happen at all;
- No person should lack essential public health protection;
- The presence of a functioning health department in every local community would eliminate any gaps in the surveillance, prevention, and control of public health threats, such as communicable diseases, from one community to the next; and
- Local populations would have direct oversight of public health practice to assure that resources are used for local priorities and problems.

Ultimately, all public health is local public health— where people live. It is at the local level that all of the department's programs and units meet to have their impact. But currently TDH sends its resources to its regional public health offices or directly

to local entities in categorical packages, which makes it difficult to perform the wide variety of public health functions in communities in a comprehensive manner. Categorical program staff members must focus on performing the particular duties of their particular program. While the department will always need the expertise of programmatic specialists in technical areas of public health practice, few staff have the flexibility to work first for a community and all its varied health needs. Multiple categorical and disease-specific programs are not an adequate substitute for effective local public health systems.

Strong local public health systems are capable of identifying their own community needs through local data and local priorities and mobilizing responses to their needs. An effective state public health system allocates its resources and program expertise to support and enhance local public health systems.

Appendix C points out opportunities for aligning and coordinating the two hundred programs and units of TDH. The efficiency and effectiveness of TDH programs can be improved in no greater way than by aligning their resources to develop, respond to, and support public health at the local level. In this alignment lies the potential for a seamless system for the implementation of essential public health functions from the national level to the local level.

TARGET FOUR: Build and enhance essential public health functions at the local level

The department will continue to build and enhance essential public health functions at the local level through stronger partnerships with local health departments and with new local public health entities being created through TDH regional offices.

TDH will:

1. Create model programs of regional and local public health that foster community involvement and planning.
 - a) Evaluate existing local public health model units (including the unit in Bandera County) for effectiveness in ensuring the performance of the essential public health functions.

- b)** Appropriate to the findings of the evaluation, adapt and implement model local public health units where none currently exist.
- c)** Provide technical assistance to local public health entities in performance of essential public health functions (such as the development of community health profiles) to improve community health status. Fulfillment of this function may require reprioritization of resources within the department.
- d)** Establish an Office of Public Health Practice within the department in order to coordinate, support, and assess Texas’s public health entities, including assessment based on the National Public Health Performance Standards.

2. Increase state and local organizational capacity to perform essential public health functions through community outreach and training public health professionals.

- a)** Realign department staff to work more effectively through “generalizing.” Continue the development and implementation of the TDH Generalist Corps (a group of employees specially trained in community public health and oriented toward the local public health system) so that one percent of the TDH workforce is employed at the community level as public health generalists by 2002 and 2.5 percent is so employed by 2005.
- b)** Coordinate a curriculum for TDH generalists to ensure competency and skill in performing specific essential public health functions (e.g. epidemiology, public health planning, surveillance, monitoring, evaluation, as well as project management).
- c)** In collaboration with Texas schools of public health, develop and implement appropriate curricula for training local public health authorities, local boards, local officials, local health department directors, and other public health employees.

3. Establish standards and methods for monitoring health status indicators and public health performance, including the implementation of essential public health functions.

- a)** Establish community health indicators that can be used to guide the development of local, regional, and state public health improvement plans.
- b)** At the central and regional levels, provide assistance to guide communities in collecting, analyzing, and interpreting health information and using the information to prioritize health issues.
- c)** Identify priority health issues for the state through the analysis of community level and statewide registry health information.
- d)** Adopt the federal Public Health System Performance Assessment Tool for state and local levels for assessment and evaluation purposes.

TARGET FIVE: Strengthen Regulatory Activities

Problem

“Although a full investigation of the 55 regulatory programs was not possible, Sunset staff found enough significant concerns to recommend that TDH conduct a comprehensive evaluation of its regulatory functions with assistance from the State Auditor’s Office.” (TDH Sunset Advisory Commission Staff Report, p.13, 1998)

Background

Over the last 80 years, the Texas Department of Health’s regulatory responsibilities have evolved to include many programs which are divided primarily between two Associateships - Health Care Quality and Standards and Environmental and Consumer Health. Among these programs are eleven independent professional licensing boards which are administratively attached to TDH but have independent rule-making authority. Fifteen divisions in five bureaus administer these programs, which regulate a wide variety of approximately 250,000 public health professionals, facilities, and businesses that provide goods and services to 20 million Texas consumers. The primary purpose of these programs is to prevent illnesses and injuries by assuring that these regulated entities comply with applicable rules and statutes. TDH regulatory programs ensure compliance mainly through inspections, investigation of complaints, using enforcement sanctions, and licensing and certification.

Some of TDH’s programs have been individually evaluated internally and externally, but the department has never done a comprehensive evaluation of all of its regulatory programs at the same time. The last external evaluations were done by the State Auditor’s Office in 1997-1998 and focused on TDH’s Professional Licensing and Certification Division and Home Health Program. The main challenges in TDH’s current regulatory review include the wide diversity of TDH’s regulatory programs, defining and measuring effectiveness of programs, including industry and public representatives in the review process, and obtaining buy-in from all levels. Appendix E provides an interim report of the department’s regulatory review process.

TARGET FIVE: Strengthen regulatory activities.

TDH will strengthen its regulatory activities.

The findings and recommendations in the final TDH Regulatory Review report due to the Board of Health and Legislature by November 1, 2000 will identify methods and actions required to strengthen TDH regulatory activities.

TARGET SIX: Integrate the Function of Health Care Delivery Programs

Problem

The current administration of health care delivery programs in the department results in fragmented services for clients. Each program or service has separate eligibility processes that clients must navigate, requiring them to report the same information repeatedly. Clients may not have the benefit of continuity of care and are not ensured a medical home.

Many of the department's processes create undue burdens for providers of multiple health care delivery services. The department's contracting process requires providers of multiple programs to duplicate efforts regarding community needs assessment, certifications, and assurances, while holding separate contracts for each of the categorical funding sources. The many health care programs within the department do not use standard terminology, common practice standards, integrated eligibility requirements, common reporting and billing systems, or standard reimbursement methodologies.

Background

As Chapter One pointed out, health care delivery programs have been part of the department's responsibilities as early as 1922 in the Bureau of Child Hygiene. After expansion in the mid-1940s and efforts to increase access to health care from the 1960s through the present, the largest part of the department's budget today funds the provision or purchase of health care services for medically indigent individuals or people with special health care needs.

Programs were created to meet health care needs of segments of the population as funding became available and authorization occurred. The department seized opportunities as they arose, but new programs were not added with a master plan in mind. Facing the strict accountability requirements that came with categorical funding, the department tended to set up separate programs in separate administrative units.

Since many of these programs exist to serve the population that does not qualify for Medicaid or Medicare, the eligibility requirements and caseloads of the department's smaller programs are subject to shifts in state and federal policy for Medicaid and Medicare. For this reason program policies are linked, but administration of the programs (particularly budgets, contracting, and quality assurance) has not been coordinated fully as yet.

In 1999, House Bill 2085 required the department to “integrate the functions of its different health care delivery programs to the maximum extent possible, including integrating the functions of health care programs that are part of the state Medicaid program with functions of health care delivery programs that are not part of its Medicaid program.” The legislation required that integration should be accomplished, to the extent possible and allowable by law, within and across the development of health care policy, delivery of health care services, and the administration of contracts. Finally, the legislation requires the implementation of a pilot project that integrates all appropriate functions of the department's health care delivery programs. Appendix H provides a detailed report of the activities, plans, and accomplishments of the department's Service Delivery Integration Group, created to implement this legislative charge.

TARGET SIX: Integrate the function of health care delivery programs

TDH shall integrate the functions of its health care delivery programs. At a minimum, integration includes health care policy development, health care service delivery and contracts administration. This will be accomplished through a process that involves all stakeholders.

TDH will:

1. Develop a system to pilot by September 2000 which simplifies and integrates health care policies, administrative policy, and medical standards for delivery of integrated health care services.

- a) Identify management and planning teams.

- b)** Define the scope of the pilot project.
 - c)** Develop processes that integrate administrative health care policies including eligibility, medical standards, community resource information, client/family education, and case coordination assistance.
 - d)** Determine selection criteria for potential pilot sites and select pilot sites.
 - e)** Develop implementation plans for integrated contracting, eligibility, billing and reporting systems, including training and technical assistance for pilot contractors.
- 2.** Implement a pilot project that integrates all appropriate functions of the health care delivery programs.
 - a)** Implement the pilot project from September 2000 through August 2002.
 - b)** Evaluate the pilot by September 2002.

TARGET SEVEN: Involve stakeholders in agency planning and decision-making

Problem

The Texas Department of Health lacks a consistent process for soliciting stakeholder input in identifying community needs, health priorities, program/service development, and the rule making process. Although it is recognized that TDH is a complex agency with many diverse programs interacting with diverse stakeholders, a one-size-fits-all approach may not be effective. At the same time, consistency in philosophy and approach is needed.

Background

Topics related to public health are often controversial - politically, socially, and economically. Issues related to appropriate levels of Medicaid coverage, government regulation of business, provision of family planning services to minors, and protection of the confidentiality of medical/health information are all highly controversial.

These and other issues elicit a wide variety of opinions and often those opinions are conflicting. As a result soliciting the input of *stakeholders* (defined as any individual, group, or institution that has an interest or stake in the decisions or actions of an organization) is often a difficult task. Feedback and experience from past stakeholder involvement processes at the department are detailed in Appendix F. These findings reveal key issues that need to be addressed to improve such processes in the future.

1. Some stakeholder involvement activities appear to be conducted because they are considered “a good thing” (quotation from stakeholder focus group participant) but it is not clear how the activities contribute to actual department decisions. TDH has not maximized input from stakeholders and other experts during the development and evaluation of their programs.

This “cold shoulder” (quotation from stakeholder focus group participant) has led to frustration as participant expectations do not coincide with department actions.

2. Department staff does not always have an understanding of the type of stakeholder involvement that is most appropriate in a particular situation, and so the approach selected might not produce the type of results that are needed. Planning and managing effective, ongoing stakeholder involvement activities requires skills that many TDH staff members have not developed as highly as their scientific or technical skills. Continuing education opportunities should be made to staff to learn about stakeholder tools and techniques including:

- Public hearings
- Advisory groups
- Surveys
- Stakeholder analysis
- Forums
- Coalitions
- Focus groups
- Fact-finding
- Mediation
- Arbitration
- Participatory planning
- Strategic alliances

3. The department should establish an open communications policy as the foundation to build trust with stakeholders.

4. The department should establish a process for audit and disclosure of how well it is working with its stakeholders.

TARGET SEVEN: Involve stakeholders in agency planning and decision-making

The Texas Department of Health will engage stakeholders in the determination of health needs and priorities at the local, regional, and state levels and offer involvement in public health program planning and decision-making.

TDH will:

1. Enhance the department's policies, capacities, and skills to involve stakeholders in agency planning and decision-making.

- a)** Require that a stakeholder plan be developed by programs prior to rule making which:

- Justifies the need for the rule;

- Analyzes workload and fiscal impact of proposed rules;

- Identifies external and internal stakeholders and the methods of communication for soliciting stakeholder input;

- Evaluates the use of negotiated rule making;

- Discusses the role of an advisory, ad hoc, or steering committee/council;

- Establishes a stakeholder friendly time line;

- Receives senior management approval; and

- Displays on the TDH web site.

- b)** Create a position within the department that is responsible for overseeing and facilitating the customer service, advisory council, and general stakeholder involvement functions and provide technical assistance to programs in developing their stakeholder plans for rulemaking and working with stakeholders.

- c) Train TDH staff in the tools and techniques for effectively involving stakeholders. Develop a toolbox to include a statement of TDH's general stakeholder principles and guidance on how to effectively use stakeholder involvement tools. Provide training on the toolbox for staff.
- d) Develop and maintain a stakeholder information system at the program level with the capability to generate electronic and regular mail to inform stakeholders of opportunities.
- e) Clarify the roles and responsibilities of advisory committee/group members through a statement from the Board of Health and department executive staff. Train advisory committee/group members on their role(s) and responsibilities.
- f) Improve targeted communication about department activities and products to key stakeholder groups. Facilitate state and regional communication about TDH products designed for key constituents. Develop a communication network among the local, regional, and state levels to solicit, share, analyze, and apply stakeholder input.

2. Enhance stakeholder capacity to participate in department planning and decision-making.

- a) Create opportunities at the local and regional levels for stakeholders to assess and identify health needs and priorities through community health profiles and public health improvement plans.
- b) Adopt the components of essential service #4 of the *Centers for Disease Control and Prevention State and Local National Performance Standards - Mobilize Partnerships to Identify and Solve Health Problems*. (See Appendix F of this document.) The components of this

essential service will help to develop systems for stakeholder input at the state and local levels.

- c) Create a website for stakeholder involvement (stakeholder opportunities, listing of technical assistance available to stakeholders, reports on stakeholder activities).

3. Produce an evaluation of the department's effectiveness in using stakeholder input, to be included in subsequent Comprehensive Strategic and Operational Plans.

- a) Establish an oversight committee comprised of diverse external stakeholders to annually review agency effectiveness in stakeholder development and management and to include the findings in subsequent Comprehensive Strategic and Operational Plans.
- b) Include an evaluation of the department's progress in effectively engaging internal stakeholders (central and regional employees).

Index of Responses to HB 2085 Blueprint Charges

Familiar Name	Charge from HB 2085	Response in Blueprint
TDH Missions	Sec. 11.0045. (c) (1) a statement of the aim and purpose of each of the department's missions, including (A) the prevention of disease; (B) the promotion of health; (C) indigent health care; (D) the protection of parents' fundamental right to direct the health care and general upbringing of their children; (E) acute care services for which the department is responsible; (F) health care facility regulation for which the department is responsible; (G) the licensing of health professions for which the department is responsible; and (H) all other health-related services for which the department is responsible under law;	<ul style="list-style-type: none"> • Chapter One* • Targets One and Three • Appendices B and E
TDH Missions	Sec. 11.0045. (c) (2) an analysis regarding how each of the department's missions relate to other department missions;	<ul style="list-style-type: none"> • Chapter One* • Targets One and Three • Appendices B and E
Program Integration	Sec. 11.0045. (c) (3) a detailed analysis of how to integrate or continue to integrate department programs with other department programs, including the integration of information gathering and information management within and across programs, for the purpose of minimizing duplication of effort, increasing administrative efficiency, simplifying access to department programs, and more efficiently meeting the health needs of this state;	<ul style="list-style-type: none"> • Chapter Two • Targets One,* Two, Four, Five, and Six* • Appendices C,* D, E, H*
Program Integration	Sec. 11.0045. (c) (4) a detailed proposal to integrate or continue to integrate department programs with other department programs during the two-year period covered by the plan, to the extent allowed by law and in accordance with the department's analysis;	<ul style="list-style-type: none"> • Targets One,* Two, Four and Six* • Appendices C, D, and H*

* Items with asterisks are the primary reference for the topic in the blueprint. Other sections reference relevant and supporting information.

Familiar Name	Charge from HB 2085	Response in Blueprint
Data Management	Sec. 11.0045. (c) (5) a determination regarding whether it is necessary to collect each type of information that the department collects, and for each type of information that it is necessary for the department to collect, whether the department is efficiently and effectively collecting, analyzing, and disseminating the information and protecting the privacy of individuals;	<ul style="list-style-type: none"> • Chapter Two • Target Two* • Appendices A, D,* and F.
Internal Assessment (aka Program Interviews)	Sec. 11.0045. (c) (6) an assessment of services provided by the department that evaluates the need for the department to provide those services in the future;	<ul style="list-style-type: none"> • Chapters One and Two* • Targets One,* Two, Four,* and Five • Appendices C* and D
Stakeholders	Sec. 11.0045. (c) (7) a method for soliciting the advice and opinions of local health departments, hospital districts, and other public health entities, of recipients and providers of services that are related to the department's missions, and of advocates for recipients or providers for the purpose of identifying and assessing: (A) the health-related needs of the state; (B) ways in which the department's programs and information services can be better integrated and coordinated; and (C) factors that the department should consider before adopting rules that affect recipients or providers of services that are related to the department's missions;	<ul style="list-style-type: none"> • Chapter Two • Target Seven* • Appendix F*
Health Information	Sec. 11.0045. (c) (8) a comprehensive inventory of health-related information resources that meet department criteria for usefulness and applicability to local health departments, to recipients or providers of services that are related to the department's missions, and to nonprofit entities, private businesses, and community groups with missions that are related to health;	<ul style="list-style-type: none"> • Chapter Two • Target Two* • Appendices C and D*
Coordination with other Agencies	Sec. 11.0045. (c) (9) a statement regarding the ways in which the department will coordinate or attempt to coordinate with federal, state, local, and private programs that provide services similar to the services provided by the department;	<ul style="list-style-type: none"> • Chapters One and Two • Targets One,* Four,* Six*, and Seven* • Appendices E, F, and H*

* Items with asterisks are the primary reference for the topic in the blueprint. Other sections reference relevant and supporting information.

Familiar Name	Charge from HB 2085	Response in Blueprint
Mandated Plans	Sec. 11.0045. (c) (10) a list of other plans that the department is required to prepare under state law and a recommendation regarding which plans are obsolete or duplicate other required department plans; and	<ul style="list-style-type: none"> • Target One* • Appendices C and G*
Mandated Plans	Sec. 11.0045. (c) (11) an assessment of the extent to which previous plans prepared by the department under this section have effectively helped the department to identify and achieve its objectives, to improve its operations, or to guide persons who need to identify department services, identify department requirements, or communicate effectively with department personnel.	<ul style="list-style-type: none"> • Mechanism for this future evaluation is in Target One*
Rule Development Process	Sec. 12.004. (b) The board shall require the department to establish a checklist of methods that, to the extent appropriate, the department will follow to obtain early in the rule development process the advice and opinions of the public and of persons who will be most affected by a proposed rule. The checklist must include methods for identifying persons who will be most affected and for soliciting at a minimum the advice and opinions of affected local health departments, of recipients and providers of affected services, and of advocates for affected recipients or providers.	<ul style="list-style-type: none"> • Target Seven* • Appendix F*
Service Delivery Integration (SDI)	<p>Sec. 12.0115. (b) The department shall integrate the functions of its different health care delivery programs to the maximum extent possible, including integrating the functions of health care delivery programs that are part of the state Medicaid program with functions of health care delivery programs that are not part of the state Medicaid program.</p> <p>Sec. 12.0115. (c) At a minimum, the department's integration of the functions of its different health care delivery programs must include the integration within and across the programs of: (1) the development of health care policy; (2) the delivery of health care services, to the extent appropriate for the recipients of the health care services; and (3) to the extent possible, the administration of contracts with providers of health care services, particularly providers who concurrently provide health care services under more than one contract or program with the department.</p>	<ul style="list-style-type: none"> • Chapter Two • Target Six* • Appendix H*

* Items with asterisks are the primary reference for the topic in the blueprint. Other sections reference relevant and supporting information.

Familiar Name	Charge from HB 2085	Response in Blueprint
Regulatory Review	SECTION 1.23. (a) The Texas Department of Health, with the assistance of the state auditor, shall conduct a comprehensive evaluation of the department's regulatory functions. The evaluation must include an examination and analysis of the effectiveness of the department's: (1) rules that affect or support its regulatory practices; (2) inspection efforts, including its scheduling of inspections and consistency between inspections; (3) investigative practices, including investigations conducted in response to a complaint; (4) use of sanctions; (5) enforcement actions in relation to the time it takes to initiate and complete an enforcement action and in relation to the role of the department's office of general counsel; (6) efforts to ensure compliance with applicable laws and rules; and (7) efforts to ensure the consistency and appropriateness of the training of inspectors, including ensuring that: (A) inspectors are familiar with the type of facility and with the type of care provided at a facility that they inspect; and (B) the skills and knowledge of inspectors remain current through continuing education and review.	<ul style="list-style-type: none"> • Chapter 2 • Target Five* • Appendices C and E*

* Items with asterisks are the primary reference for the topic in the blueprint. Other sections reference relevant and supporting information.